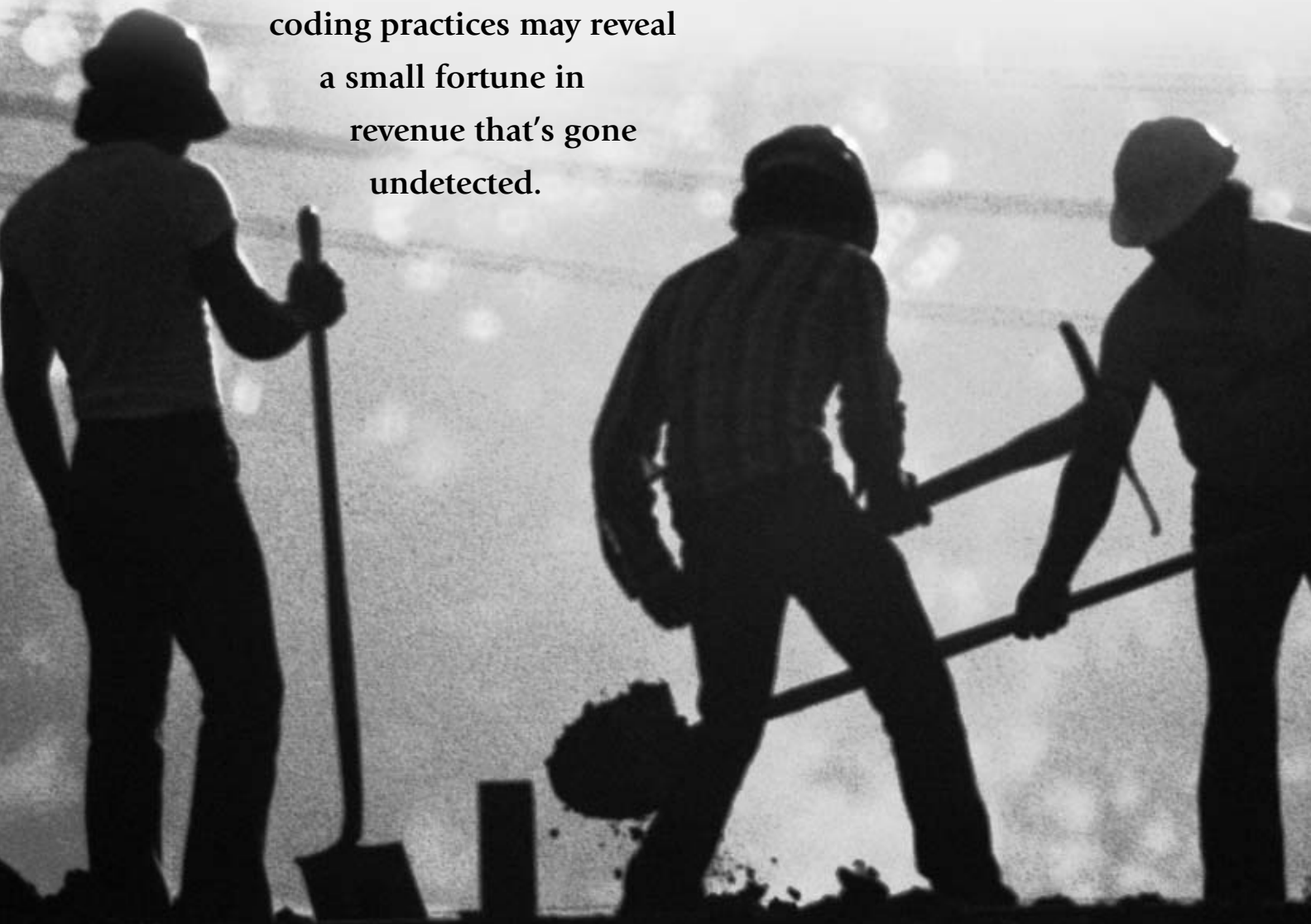


# FOR THE RECORD

A closer inspection of your coding practices may reveal a small fortune in revenue that's gone undetected.



# Digging *for* Dollars

By Robbi Hess

**I**ncorrect or incomplete coding results in cashflow losses that could reach the hundreds of thousands of dollars if the situation isn't unearthed early enough. Uncovering and correcting coding errors or documentation problems could be like discovering buried treasure when it comes to "found" money.

"An occasional aberrancy to coding performance is not something to be overly concerned with," says Gayl Kirkpatrick, RHIT, CCS, senior manager, consulting services for 3M Health Information Systems. "It's the overall trends in coding that a facility has to review. If the trends aren't completely aligned with coding rules and regulations, they must be addressed."

## **Errors, Missing Information, Delayed Reimbursements**

Physicians, clinicians, and coders all agree that proper documentation is the first step in the smooth transition from transcription to coding, billing, and eventually reimbursement.

Even though everyone agrees that is the case, there is still a disconnect with coding errors that begins at the point of care. "Physicians and clinicians must correctly and completely document procedures in order to ensure that coders and billers have enough information to code compliantly and bill properly for all services performed," says Arvind Subramanian, chief operating officer at ProVation Medical, a documentation and coding software company.

Under the traditional method of dictation and transcription, the best-case scenario is for the doctor to dictate his notes literally as soon as he strips off the latex gloves. Unfortunately, Subramanian explains, that rarely happens.

"At most facilities, doctors perform procedure after procedure throughout the course of the day and eventually dictate hours or days later based on recollection or quick handwritten notes," he says. "Inevitably, important details and portions of the procedures are lost—and so is the opportunity to code and be reimbursed for those details."

"Using software to document a procedure immediately after it is performed, at the point of care, solves many of these problems," Subramanian continues. "A software application that prompts clinicians to document immediately and completely, then links codes to the supporting documentation, is the best solution."

## **Documentation, Documentation, Documentation**

Because facilities get reimbursed only for what they document, not necessarily what they did, the importance of complete notes from physicians and clinicians is paramount. If a coder has to base his or her code selections on incomplete or inadequate documentation, the result is defensive undercoding and lower reimbursement.

"Most physicians aren't aware of the extent to which their documentation determines the amount paid for their services, and coders often end up with notes

that must either be undercoded due to missing or inadequate documentation or sent back to the physician for clarification," says Subramanian. "By automating the process of entering procedure notes, software reduces demands on physicians' and coders' time, plus it increases the accuracy and completeness of notes, ensuring the inclusion of all billable services."

The secret to the success of any documentation or coding software is, ultimately, ease of use for the end user. "The reason ProVation software works is that it was designed by doctors for doctors and by coders for coders," Subramanian says. "One of the rules when we designed the program was that it had to allow the physician to document a note as fast or faster than it would be if he or she dictated."

Frequent denials and loss of revenue are sure signs that a facility's coding is askew. But Chris Cousins, vice president of operations at Payerpath, says while denials are a problem that is tangible, there are other intangibles, such as a facility not receiving the correct reimbursements for procedures. "You see the denials coming back but how do you know if your reimbursements are at the levels they are contracted for?" he asks. The poor man's alternative to employing a sophisticated contract management tool is to track reimbursements by pulling out a copy of the contracted fee schedule with the payor and comparing it to the received reimbursement.

Paula Bruce, RHIT, CCS, coding manager at Florida's Halifax Medical Center, says her facility started a clinical docu-

mentation program with Case Management as a way to improve doctors' documentation. "While the patient is in-house, the case managers and coding staff work together to see what should be documented by the physician based on the treatment plan to ensure optimal reimbursement and justify medical necessity," she explains. "If a patient has any other coding conditions going on that they are being treated for, these conditions should be documented in the medical record."

Education of staff, including billing, coding, physicians, and other clinicians, needs to be ongoing, Bruce says. "A way we educate physicians on coding and reimbursement issues is to attend their committee meetings to educate them on how more detailed documentation in the medical record can impact the hospital's reimbursement, which will benefit them. This allows the hospitals to buy the expensive medical equipment they need to treat their patients."

A practice has to make certain the charge data capture gathered within its practice management system is synchronous with what's in the patient's chart. "If a diagnosis doesn't support the level of code being billed, you have to go back to the doctor and ask for more supporting documentation or review of the diagnosis code and in essence you're now delaying payment," Cousins says.

### **Audit Reviews**

Setting up coding audits can help a hospital monitor and establish focus areas. A focused approach at determining whether coding is going askew is to look at the initial diagnostic related group (DRG) assignments—those that would be affected by a symptom rather than a principal diagnosis.

There is so much information the coding staff is required to know and remember. Bruce says software is available that offers built-in reviews so coders don't have to remember the myriad coding rules and regulations. "Hospitals also need to set up their own custom rules to flag certain records for review," she states.

Kirkpatrick explains, "If you had a DRG that indicates chest pain but the pa-

tient has a length of stay of six days, that suggests that a coder should look at the record again and see if there is an underlying etiology for the chest pain that wasn't captured initially."

What a practice does within its four walls to add edits and coding requirements within its practice management system allows for a cleaner claim.

"You need to do some analysis in-house to see what can be done to head off denials and to make sure your practice doesn't find itself in an audit situation," Cousins says. "Submitting a properly coded claim the first time gets the reimbursement check in the mail sooner rather than being subjected to a long, potentially frustrating appeal process."

In a doctor's office, Cousins says, coding from a clinician standpoint is all paper unless the practice is using an electronic medical record (EMR). The paper encounter form contains the visit and charge data and accompanies the patient throughout the visit.

"Once the patient encounter form is turned in, at the time of check, an electronic invoice is created in the practice's PMS [patient management system]," he says. "Hopefully, the charge entry clerk or coder doesn't misread what's listed on the form or enter *CPT [Current Procedural Terminology]* codes mismarked on the form. It's all about accurate documentation."

Facilities should also be looking at their denial trends.

"Look for the root causes of denials," Cousins states. "What's triggering them and build 'upstream' edits within the practice's PMS system to head off future denials."

### **Raising the Red Flag**

Large volumes of rebills—where initial coding was for a lower-weighted procedure than the one subsequently resubmitted raises a red flag with auditors, Kirkpatrick says. "Also, if you have high-weighted DRGs with short lengths of stay, indicate that additional auditing should be performed—either internally or externally."

A mismatch between professional and facility codes is one of the biggest red flags to the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), or other auditing bodies, ac-

ording to Allison Errickson, CPC-H, compliance manager at ProVation Medical.

"Separate coders review documentation and generate two separate bills—one for professional fees, which determine physician reimbursement, and one for facility fees, which determine the amount the medical facility will be reimbursed for the procedure," she says. "Incomplete documentation is often interpreted differently by different coders—and if the physician bills for services that vary from those submitted by the facility, it raises a red flag with payors and auditors."

Errickson says another area of potential fines and denials is incorrect "bundling" of codes—billing separately for a procedure or aspect of a procedure that is already included (bundled) with other maneuvers under one main code. Called Correct Coding Initiative (CCI) edits, these bundled codes are updated and released on a quarterly basis from the CMS. "If a facility isn't using the most up-to-date CCI edits," she says, "claims will be denied by both Medicare and third-party payors, and a facility is open to fines for noncompliance."

Undercoding is as costly and detrimental to a facility's bottom line as incorrect coding. Overutilization of higher-weighted codes that fall out of the "bell curve" raises questions, according to Cousins.

"Any type of code that falls out of the normal coding curve of demographics or for the geographic area should be checked in-house," he says. "A facility needs to have documentation to support every bit of coding that was done."

Bruce says, "If your hospital has an extremely high volume of a heavily weighted DRG compared to other facilities in your area, that could raise a red flag." As an example, Bruce explains that if DRG 79 is a higher-weighted payment and you performed 650 of those procedures in one year and only 70 of the lower-weighted DRG 80, your facility is off balance and that could trigger an audit. Comparisons between your facility and a neighboring one are a good measure of whether your facility is performing an inordinate amount of one type of DRG.

Cousins says an overabundance of claims filed with the modifier noting that a medical necessity waiver is on file is another example of a potential red flag to an auditor.

“Physician offices should avoid having ‘blanket’ waivers signed by patients,” he says. “The clinician should make the determination prior to ordering or performing the test or procedure and have the waiver completed as needed at the time of care.”

### **In-house Compliance**

A coding compliance plan is the largest part of an overall billing compliance program. Internal audits should be part of everyday management. In addition to a review of high-weighted DRGs with short lengths of stay, Kirkpatrick says audits should look at DRGs indicating a symptom as the principal diagnosis, with long hospital stays. This describes a focused approach to auditing. HIM departments should also consider external reviews to supplement internal reviews to be certain the facility is in compliance.

“Also, rotate reviews of coding staff so that for the first quarter you randomly review coders, evaluating one [percent] to 10% of their records,” Kirkpatrick explains. “Then, provide those coders with the necessary education to ensure they are familiar with the most current codes and rules. Document all internal audit and education activities as a way to monitor compliance.”

However, Kirkpatrick says, it’s not enough to simply perform audits. “You have to trend DRG performance to determine whether an incorrect DRG assignment is an infrequent occurrence or if it is an ongoing trend that needs to be investigated,” she says. “On a periodic basis, it’s advisable to have an external auditing organization do a coding review so that you receive an objective opinion.”

With coding compliance, facilities must identify the areas where trends are occurring and where denials are emanating from, and then implement education to address those trends.

Kirkpatrick says facilities must ensure their entire coding staff remains aware and educated on new codes. Published regulations and coding guidelines should be disseminated to the entire staff. “You have to make sure that all coders understand the guidelines in the same way. There should be no room for individual interpretation of coding data,” she stresses.

Cousins is an advocate of proactive

chart auditing. “A practice should have in place certain protocols of how information is to be organized in a chart so if you are responding to an audit inquiry, the information is readily accessible,” he explains.

There is also a plethora of tools available to clinicians and coders to ascertain that codes and diagnoses mirror one another.

“Coders and facilities need to ensure that the most appropriate diagnosis code is selected and the services provided are appropriately ‘linked’ to the diagnosis code being used,” Cousins says.

Also, if there are payor-specific requirements for the frequency in which tests or procedures will be covered and reimbursed, such as only ordering mammograms annually, submitting claims for those tests outside the requirements could

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be a sign that the facility is improperly ordering tests and diagnostics, Cousins says.

Coding management staff need to work closely with the patient accounting department to review denials to discern the underlying reasons for the denials. The information can then be backtracked to correct it at the outset.

### **Revenue Recovery and Management**

Subramanian estimates that less than 20% of U.S. medical facilities are using some kind of software to automate procedure documentation. Facilities have long spent budget dollars on the clinical side—research, instruments, new treatments, etc—and have neglected an investment in an information technology infrastructure that can streamline processes and actually help generate more revenue. That mindset, Subramanian says, is changing.

Medical facilities are beginning to look at procedure volumes and coding er-

ror rates to estimate the return on investment for technology that can fix the problem. “The average error rate at any given site ranges anywhere from 10% to 25%,” Subramanian says. “And you will usually find that coders are defensively undercoding because they are nervous about the risk of overcoding.”

How much money is being lost? “We did a [presoftware/postsoftware] study with one of our clients that showed the facility was losing close to \$300,000 a year before it implemented our software simply because their documentation was incomplete and they were undercoding,” he says. “The ability to recover that revenue makes a huge difference to the financial health of a medical center.”

### **Fines and Sanctions**

Government fines for coding errors can range as high as \$10,000 per line item, Errickson says. The lowest penalty would be paying back the dollars billed in error.

The OIG has hundreds of auditors to be on the lookout for coding errors and everyday mistakes. Losing the ability to receive reimbursement for Medicaid procedures, Bruce says, would be a huge financial blow to a hospital.

Protection against coding fraud and abuse liability starts with having good policies and procedures in place and making use of the tools available to complement the core PMS being used by the provider, Cousins explains.

“Once a problem’s been identified, document what you’ve identified and how you will correct it. That documentation and in-house investigation is a better defense than saying ‘We didn’t even know this was happening’ if you’re being audited,” he says. “It’s necessary to have an action plan in place.”

The bottom line, Bruce says, is ongoing education for coders and medical staff. “They also have to ensure that documentation is in place for the treatment that was rendered so hospitals get paid correctly and in a timely manner.”

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